State of New Hampshire
Board of Medicine
Concord, New Hampshire

In the Matter of:
Stephen J. McColgan, M.D.
No.: 7583
(Misconduct Allegations)

SETTLEMENT AGREEMENT

In order to avoid the delay and expense of further proceedings and to promote the best interests of the public and the practice of medicine, the New Hampshire Board of Medicine ("NH Board") and Stephen J. McColgan, M.D. ("Dr. McColgan" or "Respondent"), a physician licensed by the NH Board, do hereby stipulate and agree to resolve certain allegations of professional misconduct now pending before the NH Board according to the following terms and conditions:

1. Pursuant to RSA 329:17, I; RSA 329:18; RSA 329:18-a, and Board of Medicine Administrative Rule ("Med") 206 and 210, the NH Board has jurisdiction to investigate and adjudicate allegations of professional misconduct committed by physicians. Pursuant to RSA 329:18-a, III, the NH Board may, at any time, dispose of such allegations by settlement and without commencing a disciplinary hearing.
2. Pursuant to RSA 329:17-c and Med 504.01, the NH Board also has jurisdiction to proceed with a reciprocal proceeding against a physician upon receipt of an administratively final order from the licensing authority of another jurisdiction which imposed disciplinary sanctions against the physician.

3. If a reciprocal proceeding were conducted, the NH Board would be authorized to impose any disciplinary sanction permitted by RSA 329:17, VI; RSA 329:17-c; and Med 504.01 (b).

4. In order to avoid the delay and expense of further proceedings and to promote the best interests of the public and the practice of medicine, the NH Board and Respondent, agree to settle certain allegations of professional misconduct, which arose in the State of California and are now pending before the NH Board., by means of a reciprocal discipline proceeding, in accordance with the following terms and conditions:

5. The NH Board first granted Respondent a license to practice medicine in the State of New Hampshire on May 6, 1987. Respondent holds license number 7583. Respondent is a general surgeon whose practice is located at 9604 Artesia Boulevard, Suite 200, in Bell Flower, California.

6. If a disciplinary proceedings were commenced, Hearing Counsel would prove that on August 21, 2006, a final administrative order ("Order") was issued against Dr. McColgan by the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs of the State of California ("Medical Board of California" or "California Board"). The Order resolved pending disciplinary matters pending before the California Board. Pursuant to the Order, Dr. McColgan was publicly reprimanded and required to enter and complete continuing medical education ("CME") offered by PACE relating to prescribing practices. This CME was to be completed no later than August 21, 2007. The conduct underlying the reprimand and CME requirement constitutes unprofessional misconduct pursuant to RSA 329:17, VI (d). *See* **Attachment A.**

7. As a basis for proceeding against Respondent, the NH Board states the following:

A. On August 21, 2006, the Medical Board of California issued a final administrative order regarding the disposition of disciplinary matters relating to repeated negligence, incompetence, violation of drug statutes, failure to maintain adequate records during Respondent's treatment of his ex-wife JM during the time period 1999 – 2004, and of his minor child CM during the time period of 1998 - 2003.

B. The NH Board received notification of the action by the Medical Board of California on August 9, 2006.

8. Respondent agrees that by the above stated conduct, he violated the provisions of RSA 329:17, VI(d).

9. Respondent acknowledges the NH Board's authority to impose reciprocal discipline against him, pursuant to RSA 317:17-c, Med 504.01, and Med 506.02 and based upon the final administrative order of the Medical Board of California ("Order") which imposed discipline against him.

10. Respondent consents to the following disciplinary and reciprocal action by the NH Board:

A. Respondent is Reprimanded.

B. Respondent shall provide documentation to the NH Board of his compliance with the terms of the Medical Board of California Order no later than August 21, 2007.

C. For a continuing period of one (1) year from the effective date of this *Settlement Agreement*, Respondent shall furnish a copy of this *Settlement Agreement* to any employer to which Respondent may apply for work as a physician or for work in any capacity which requires a medical degree and/or medical license or directly or indirectly involves patient care, and to any agency or authority that licenses,

certifies or credentials physicians, to which Respondent may apply for any such professional privileges or recognition.

11. Respondent's breach of any terms or conditions of this *Settlement Agreement* shall constitute unprofessional conduct pursuant to RSA 329:17, VI (d), and a separate and sufficient basis for further disciplinary action by the NH Board.

12. Except as provided herein, this *Settlement Agreement* shall bar the commencement of further disciplinary action by the NH Board based upon the misconduct described above. However, the NH Board may consider this misconduct as evidence of a pattern of conduct in the event that similar misconduct is proven against Respondent in the future. Additionally, the NH Board may consider the fact that discipline was imposed by this *Settlement Agreement* as a factor in determining appropriate discipline should any further misconduct be proven against Respondent in the future.

13. This *Settlement* Agreement shall become a permanent part of Respondent's file, which is maintained by the NH Board as a public document.

14. Respondent voluntarily enters into and signs this *Settlement Agreement* and states that no promises or representations have been made to him other than those terms and conditions expressly stated herein.

15. The NH Board agrees that in return for Respondent executing this *Settlement Agreement*, the NH Board will not proceed with the formal adjudicatory process based upon the facts described herein.

16. Respondent understands that his action in entering into this *Settlement Agreement* is a final act and not subject to reconsideration or judicial review or appeal.

17. Respondent has had the opportunity to seek and obtain the advice of an attorney of his choosing in connection with his decision to enter into this agreement.

18. Respondent understands that the NH Board must review and accept the terms of this *Settlement Agreement.* If the NH Board rejects any portion, the entire *Settlement Agreement* shall be null and void. Respondent specifically waives any claims that any disclosures made to the NH Board during its review of this *Settlement Agreement* have prejudiced his right to a fair and impartial hearing in the future if this *Settlement Agreement* is not accepted by the NH Board.

19. Respondent is not under the influence of any drugs or alcohol at the time he signs this *Settlement Agreement.*

20. Respondent certifies that he has read this document titled *Settlement Agreement.* Respondent understands that he has the right to a formal adjudicatory hearing concerning this matter and that at said hearing he would possess the rights to confront and cross-examine witnesses, to call witnesses, to present evidence, to testify on his own behalf, to contest the allegations, to present oral argument, and to appeal to the courts. Further, Respondent fully understands the nature, qualities and dimensions of these rights. Respondent understands that by signing this *Settlement Agreement*, he waives these rights as they pertain to the misconduct described herein.

21. This Settlement Agreement shall take effect as an Order of the NH Board on the date it is signed by an authorized representative of the NH Board.

FOR RESPONDENT

Date: 9/14/06

Stephen McColgan, MD
Respondent

FOR THE BOARD/*

This proceeding is hereby terminated in accordance with the binding terms and conditions set forth above.

Date: 10/9/06

Penny Taylor
(Signature)

Penny Taylor
(Print or Type Name)
Authorized Representative of the
New Hampshire Board of Medicine

/* Board members, recused:

James G. Sise, M.D.

144434

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
STEPHEN McCOLGAN, M.D.	)	File No. 06-2003-146179
Physician's and Surgeon's Certificate No. G-50724	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on August 21, 2006

IT IS SO ORDERED July 20, 2006.

MEDICAL BOARD OF CALIFORNIA

By: _____
Ronald L. Moy, M.D., Chair
Panel B
Division of Medical Quality

ATTACHMENT A

BILL LOCKYER, Attorney General
of the State of California
GAIL M. HEPPELL, Supervising
Deputy Attorney General
ISMAEL A. CASTRO, State Bar No. 85452
Deputy Attorney General
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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **STEPHEN McCOLGAN, M.D.,** **9604 E. Artesia Boulevard** **Bellflower, CA 90706** **Physician and Surgeon's** **Certificate No. G 50724,** Respondent.	MBC Case No. 06-2003-146179 OAH Case No. L2006011016 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

1. An Accusation in Case Number 06-2003-146179 was filed with the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, on April 6, 2005, and is currently pending against respondent Stephen McColgan, M.D.

2. At all times relevant herein, respondent has been licensed by the Medical Board of California under Physician and Surgeon's Certificate No. G 50724, issued by the Board to respondent on or about July 18, 1983. Said certificate is current with an expiration date of September 30, 2006, unless renewed.

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3. The Accusation, together with all statutorily required documents, was duly served on the respondent and respondent filed his Notice of Defense contesting the Accusation. A copy of the Accusation No. 06-2003-146179 is attached as Exhibit "A" and is hereby incorporated by reference as though fully set forth herein.

4. The Complainant, David T. Thornton, is the Executive Director of the Medical Board of California and brought this action solely in his official capacity. The Complainant is represented by the Attorney General of California, Bill Lockyer, by and through Deputy Attorney General, Ismael A. Castro.

5. Respondent is represented by Ralph G. Helton, Esq., of the Helton Law Group, L.L.P., 401 East Ocean Boulevard, Suite 510, Long Beach, CA 90802-4967, in this matter.

6. Respondent understands the nature of the charges alleged in the Accusation and that, if proven at hearing, the charges and allegations would constitute cause for imposing discipline upon his certificate. Respondent is fully aware of his right to a hearing on the charges contained in the Accusation, his right to confront and cross-examine witnesses against him, his right to the use of subpoenas to compel the attendance of witnesses and the production of documents in both defense and mitigation of the charges, his right to reconsideration, appeal and any and all other rights accorded by the California Administrative Procedure Act and other applicable laws. Respondent knowingly, voluntarily, and irrevocably waives and gives up each of these rights.

7. Respondent admits violating Business and Professions Code section 2266 that provides, in part, "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct." In order to avoid the expense and uncertainty of a hearing in this matter, respondent agrees that he has subjected his certificate as a Physician and Surgeon to disciplinary action.

8. All admissions and recitals contained in this Stipulated Settlement and Disciplinary Order are made solely for the purpose of settlement in this proceeding and not for any other proceedings in which the Division of Medical Quality, Medical Board of California, or

other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceedings.

9. Respondent acknowledges that he shall not be permitted to withdraw from this stipulation unless it is rejected by the Medical Board of California, Division of Medical Quality.

10. Based on the foregoing admissions and stipulated matters, the parties agree that the Division shall, without further notice or formal proceeding, issue and enter the following order:

DISCIPLINARY ORDER

1. Respondent shall be, and is hereby, publically reprimanded.

2. Within 90 days of the effective date of this disciplinary order, respondent shall enroll in the PACE Prescribing course and shall successfully complete the course within one year of this date.

3. Any failure by respondent to comply with any term or condition of this order in any respect, shall constitute unprofessional conduct and permit the Board at its sole and nonreviewable election to set aside and vacate its order of adoption herein.

4. The terms and conditions set forth herein shall be null and void and not binding on the parties unless and until approved on behalf of the Board.

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ACCEPTANCE

I have read the above Stipulation for Public Reprimand. I understand the terms and ramifications of this Stipulation, and agree to be bound thereby. I enter into this Stipulation freely, knowingly, intelligently, and voluntarily.

DATED: 5/18/06

STEPHEN McCOLGAN, M.D.
Respondent

I concur as to form.

DATED: 5/18/06

RALPH G. HELTON, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulation for Public Reprimand is hereby respectfully submitted for the consideration of the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs.

DATED: 5-18-06

BILL LOCKYER, Attorney General
of the State of California

ISMAEL A. CASTRO
Deputy Attorney General

Attorneys for Complainant

Exhibit A

BILL LOCKYER, Attorney General
of the State of California
NANCY A. STONER, State Bar No. 72839
Deputy Attorney General, for
ISMAEL CASTRO
Deputy Attorney General
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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: STEPHEN McCOLGAN, M.D. 9604 E. Artesia Boulevard Bellflower, CA 90706 Physician and Surgeon's Certificate No. G 50724, Respondent.	Case No. 06-2003-146179 OAH No. **ACCUSATION**

Complainant alleges:

PARTIES

1. David T. Thornton (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

2. On or about July 18, 1983, the Board issued Physician and Surgeon's Certificate No. G 50724 to Stephen McColgan, M.D. (Respondent). The Physician and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2006, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board's Division of Medical Quality

(Division) under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the division, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the division.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the division.

"(4) Be publicly reprimanded by the division.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the division or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the division and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code states, in pertinent part:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts.[1]

"(d) Incompetence."

6. Section 2238 of the Code states:

"A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

7. Section 2241.5 of the Code states:

"(a) Notwithstanding any other provision of law, a physician and surgeon may prescribe or administer controlled substances to a person in the course of the physician and surgeon's treatment of that person for a diagnosed condition causing intractable pain.

"(b) 'Intractable pain,' as used in this section, means a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and surgeon and one or more physicians and surgeons specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain.

"(c) No physician and surgeon shall be subject to disciplinary action by the board for prescribing or administering controlled substances in the course of treatment of a person for

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1. Respondent's acts and omissions occurred prior to the January 1, 2003, effective date of the amended definition of repeated negligent acts in Business and Professions Code section 2234, subdivision (c) which now states:

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care."

intractable pain.

"(d) This section shall not apply to those persons being treated by the physician and surgeon for chemical dependency because of their use of drugs or controlled substances.

"(e) This section shall not authorize a physician and surgeon to prescribe or administer controlled substances to a person the physician and surgeon knows to be using drugs or substances for nontherapeutic purposes.

"(f) This section shall not affect the power of the board to deny, revoke, or suspend the license of any physician and surgeon who does any of the following:

"(1) Prescribes or administers a controlled substance or treatment that is nontherapeutic in nature or nontherapeutic in the manner the controlled substance or treatment is administered or prescribed or is for a nontherapeutic purpose in a nontherapeutic manner.

"(2) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Controlled Substances Act, or of controlled substances scheduled in, or pursuant to, the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal of or the dispensing of the drugs to the person and shall otherwise comply with all state recordkeeping requirements for controlled substances.

"(3) Writes false or fictitious prescriptions for controlled substances listed in the California Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

"(4) Prescribes, administers, or dispenses in a manner not consistent with public health and welfare controlled substances listed in the California Controlled Substance Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

"(5) Prescribes, administers, or dispenses in violation of either Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code or this chapter [Chapter 5, the Medical Practice Act].

"(g) Nothing in this section shall be construed to prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon, as authorized pursuant to Sections 809.05, 809.4, and 809.5."

8. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without a good faith prior examination and medical indication therefor, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with such registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refilling.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

9. Section 2266 of the Code states: "The failure of a physician and surgeon to

maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

Health and Safety Code:

10. Section 11153 of the Health and Safety Code states in pertinent part:

"(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use."

11. Section 11154, subdivision (a) of the Health and Safety Code states:

"Except in the regular practice of his or her profession, no person shall knowingly prescribe, administer, dispense, or furnish a controlled substance to or for any person or animal which is not under his or her treatment for a pathology or condition other than addiction to a controlled substance, except as provided in this division."

12. Section 11156 of the Health and Safety Code states that no person shall prescribe for or administer, or dispense a controlled substance to an addict or habitual user, or to any person representing himself as such, except as permitted by this division.

13. Section 11171 of the Health and Safety Code provides that no person shall prescribe, administer, or furnish a controlled substance except under the conditions and in the manner provided by this division.

General Unprofessional Conduct:

14. Conduct which breaches the rules or ethical code of a profession or conduct which is unbecoming a member in good standing of a profession also constitutes

unprofessional conduct. (*Shea v. Bd. of Medical Examiners*, (1978) 81 Cal.App.3d 564, 575.)

15. Section 8.19 of the American Medical Association Code of Medical Ethics, on Self-Treatment or Treatment of Immediate Family Members, generally proscribes treating immediate family members as patients and disallows prescribing controlled substances to them, except in emergency situations.

COST RECOVERY

16. Section 125.3 of the Code provides, in pertinent part, that the Division may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

MEDI-CAL REIMBURSEMENT

17. Section 14124.12 of the Welfare and Institutions Code states, in pertinent part:

"(a) Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence in the Care of Jacquie M. and Cameron M.)

18. Respondent is subject to disciplinary action under section 2234,

subdivisions (a) and (b) of the Code in that he was grossly negligent in his care, treatment, and prescribing of drugs to Jacquie M. and Cameron M.[2] The circumstances are as follows:

Jacquie M.:

19. For years, from at least 1999 through 2004, Respondent prescribed dangerous drugs and controlled substances to his ex-wife, Jacquie M. Respondent was not her primary care physician.

20. Respondent maintained a medical chart for Jacquie M., but the chart did not document any physical examinations, dates of visits, vital signs, description of presenting complaints, medical history, diagnoses, treatment plan, or monitoring of the patient's condition.

21. The medical chart for Jacquie M. contained copies of four prescriptions issued by Respondent for Ritalin, 20 mg., to be taken once daily, except for the last prescription on September 13, 2000, which was increased to twice daily.[3] Respondent did not conduct or document a physical examination, or medical indication for the prescription or increased dosage. Respondent relied on Jacquie M.'s "self-diagnosis" of Attention Deficit Disorder, without conducting or obtaining an independent evaluation.

22. The medical chart for Jacquie M. contains a telephone message in which Respondent approved a prescription of Fiorinal for Jacquie M. on or about April 14, 1999, and for Butalbital on or about January 29, 2002.[4] No other prescriptions for Fiorinal or Butalbital were documented in Respondent's records for Jacquie M. However, pharmacy records indicate

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2. Initials are used in this pleading to protect patient privacy. Respondent will be provided with identifying information if discovery is requested.

The prescriptions that are the basis of this Accusation are too numerous to set forth herein. Respondent will be provided a list of the prescriptions, including the dates, strengths and amounts of the drugs, and that list is incorporated here by reference.

3. Ritalin is a Schedule II controlled substance and a dangerous drug. It is a brand name for Methylphenidate, which is a mild central nervous system stimulant that is used to treat Attention Deficit Disorder (ADD) and narcolepsy (difficulty staying awake).

4. Butalbital Acetaminophen is a dangerous drug that requires a doctor's prescription pursuant to Business and Professions Code section 4022. Fiorinal, Fioricet, and Esgic are brand names for Butalbital. This medication is a pain reliever and sedative that is used to relieve tension headaches. The ingredient Bubalbital may be habit forming.

Respondent, or an employee or agent in his office, authorized prescriptions for Butalbital Acetaminophen for Jacquie M. 44 times between February 9, 2000, and May 18, 2004, as well as three other prescriptions for Fioricet and Esgic. Respondent did not conduct or document a physical examination or record a medical indication for these prescriptions.

23. According to pharmacy records, Respondent, or an employee or agent in his office, authorized prescriptions for Hydrochlorothiazide, 50 mg, for Jacquie M. 26 times between February 9, 2000, and May 5, 2002.[5] None of the prescriptions were documented in Respondent's chart for Jacquie M. Respondent did not conduct or document a physical examination or record a medical indication for these prescriptions.

24. According to pharmacy records, Respondent, or an employee or agent in his office, authorized prescriptions for Synthroid, 0.125 mg, for Jacquie M. 14 times between April 24, 2000, and May 5, 2002.[6] None of the prescriptions were documented in Respondent's chart for Jacquie M. Respondent did not conduct or document a physical examination or record a medical indication for these prescriptions.

25. On or about February 2, 2002, Respondent, or an employee or agent in his office, authorized a prescription for Promethazine with Codeine for Jacquie M.[7] This prescription was not documented in Respondent's chart for Jacquie M. Respondent did not

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5. Hydrochlorothiazide (HCTZ) is a dangerous drug that requires a doctor's prescription, pursuant to Business and Professions Code section 4022. This medication is a diuretic and anti-hypertensive. It is used in the treatment of edema associated with congestive heart failure, hepatic cirrhosis, and corticosteroid and estrogen therapy. Patients receiving diuretic therapy should be monitored for evidence of fluid or electrolyte imbalance.

6. Synthroid is a brand name for Levothyroxine, which is a dangerous drug that requires a doctor's prescription, pursuant to Business and Professions Code section 4022. This medication is used to supplement or replace the hormone that is normally produced by the thyroid gland for a condition known as hypothyroidism and other types of thyroid disorders. This medication should not be used wither alone or in combination with diet pills to treat obesity or for weight loss.

7. Promethazine with Codeine is a Schedule V controlled substance and a dangerous drug. Phenergan is a common brand name for this medication. It is used for the temporary relief of coughs and upper respiratory symptoms associated with allergy or the common cold.

conduct or document a physical examination or record a medical indication for this prescription.

26. According to pharmacy records, Respondent, or an employee or agent in his office, authorized prescriptions for Hydrochlorothiazide, 50 mg, for Jacquie M. 26 times between February 9, 2000, and May 5, 2002.[8] None of these prescriptions were documented in Respondent's chart for Jacquie M. Respondent did not conduct or document a physical examination or record a medical indication for these prescriptions.

27. Respondent, or an employee or agent in his office, authorized prescriptions for various other dangerous drugs for Jacquie M. between April 1999 and May 2004, including Amoxicillin, Cipro, Imitrex, Penicillin, Z-Pack, and Zovirax The prescriptions were not documented in Respondent's chart for Jacquie M. Respondent did not conduct or document a physical examination or record a medical indication for these prescriptions.

28. Respondent's medical record for Jacquie M. contains laboratory chemistry profile results, dated October 19, 2000. There is no progress note or reason given for ordering the test, and there is no evidence that the results were reviewed or that there was any follow-up on the low potassium or elevated cholesterol results.

29. Respondent ordered a pelvic ultrasound for Jacquie M. on or about October 19, 2000. He did not document any reason for the test and he did not document that he reviewed the results or followed-up on the findings that early fibroid changes were present.

30. Respondent's medical record for Jacquie M. contains a report from an upper gastrointestinal radiological exam that was requested by Respondent on or about March 21, 2003. There is no progress note or reason given for ordering the test, and there is no evidence that the results were reviewed or that there was any follow-up, or referral for treatment for the finding that the reservoir for the gastric band had become disconnected at the distal end and degenerative disc disease was noted.

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8. Hydrochlorothiazide (HCTZ) is a dangerous drug that requires a doctor's prescription, pursuant to Business and Professions Code section 4022. This medication is a diuretic and anti-hypertensive. It is used in the treatment of edema associated with congestive heart failure, hepatic cirrhosis, and corticosteroid and estrogen therapy. Patients receiving diuretic therapy should be monitored for evidence of fluid or electrolyte imbalance.

31. The following acts and omissions, taken singularly or collectively, constitute gross negligence in the care, treatment and prescribing of medications to Jacquie M.:

a. Respondent failed to conduct or document a good faith examination for all the dangerous drugs and controlled substances that were prescribed for Jacquie M.;

b. Respondent did not determine or document a medical indication for all the dangerous drugs and controlled substance that were prescribed for Jacquie M.;

c. Respondent did not conduct or document any physical examinations, dates of all visits, vital signs, descriptions of presenting complaints, medical history, diagnoses, treatment plan, or monitoring of Jacquie M.'s condition or the effects of the medications;

d. Respondent failed to document any medical justification for the diagnoses apparently being treated by prescribing dangerous drugs and controlled substances;

e. Respondent relied upon Jacquie M.'s "self-diagnosis" of ADD, without conducting or obtaining an independent evaluation;

f. Respondent failed to document all the prescriptions or refills that were authorized by him or an employees or agents in his office to be filled at the pharmacy for Jacquie M. under his name. He failed to train, properly supervise, or control his staff or other people in his office who telephoned prescriptions or refills to the pharmacy to be filled for Jacquie M. under his name;

g. By prescribing medications for chronic conditions, Respondent directly or indirectly represented himself as the treating physician for Jacquie M. who was writing or authorizing these prescriptions in the course of his usual practice when, in fact, Jacquie M. was not under Respondent's care and treatment for the conditions for which the drugs were prescribed;

h. Respondent was not a designated practitioner serving in the absence of Jacquie M.'s treating physician(s) when he issued or authorized these prescriptions, he did not limit the amount of the drugs prescribed to the amount necessary to maintain the patient until the return of her practitioner and for no longer than 72 hours, and he did not possess or utilize Jacquie M.'s medical records before ordering these prescriptions;

i. Respondent ordered laboratory and imaging tests without determining or documenting a reason for the tests. He failed to document that he reviewed or followed-up on the results, or that he consulted with or referred Jacquie M. to another physician for treatment;

j. Respondent failed to follow-up on, or to document that he treated Jacquie M.'s low potassium levels and elevated cholesterol levels;

k. Respondent failed to conduct or to document periodic patient visits with Jacquie M. to evaluate the treatment given, any side effects from the medications, and to monitor the patient's blood pressure, creatinine levels, and other criteria that should be checked on a regular basis for patients with chronic conditions such as Jacquie M.'s;

l. Respondent failed to follow pain management guidelines for prescribing medications such as Butalbital to Jacquie M., he failed to comply with the record keeping requirements and to consider, or to document that he considered, the possibility of medication abuse by Jacquie M., and whether more efficacious or prophylactic treatments could be used;

m. There was no medical indication for prescribing Synthroid, no tests were ordered or reviewed to diagnose a thyroid condition, and no monitoring of the effects of the medication was done or documented. Prescribing Synthroid to treat Jacquie M.'s obesity is inappropriate and dangerous;

n. Respondent continued to treat and to prescribe dangerous drugs and controlled substances to his ex-wife for conditions that were chronic and not emergency situations. He allowed his ex-wife to request that his staff call in prescriptions for dangerous drugs and controlled substances for herself and their daughter without independently conducting and documenting a good faith medical examination and medical indication for the drugs, and he failed to refer her care to, or consult with, another physician who was objective and properly trained to handle her medical condition.

Cameron M.:

32. For years, from at least 1998 through 2004. Respondent prescribed

dangerous drugs and controlled substances to his daughter, Cameron M. (now 15-years-old). Respondent was not her primary care physician.

33. According to Respondent, other physicians had diagnosed Cameron M. with Attention Deficit Disorder (ADD) when she was in the 4th or 5th grade. He did not obtain any records or test results from these other physicians, nor did he consult with or coordinate the care of his daughter with them.

34. Respondent maintained a medical chart for Cameron M., but the chart did not document any visits, tests or evaluations supporting the diagnosis of ADD. The only documented patient visits were for: a viral examination on or about March 25, 1997, with another physician in Respondent's office; a school physical examination by Respondent on or about August 18, 2000, which does not mention ADD; a copy of an orthodontic evaluation on or about October 24, 2002, by an orthodontist; and documentation of immunizations and medical tests for school. The chart also contains the results of a comprehensive metabolic panel performed on or about September 25, 2003, and a urine analysis done on or about July 20, 1999. There was no documentation supporting the medical indications for the tests, or that the tests were reviewed.

35. The medical chart for Cameron M. contained copies of 16 prescriptions for Ritalin issued by Respondent between April 9, 1998, and August 12, 2003. Initially the dose was 20 mg once a day, but it was increased to twice daily on or about May 1, 2001. No reason for this increased dosage is stated in the record.

36. According to pharmacy records, Respondent, or an employee or agent in his office, prescribed Promethazine with Codeine, a Schedule V controlled substance, for Cameron M. on or about December 21, 2000, April 24, 2001, and April 4, 2002. Only one prescription, for April 24, 2001, was documented in a note in the medical record for Jacquie M. Respondent did not conduct or document a physical examination or record a medical indication for these prescriptions.

37. According to pharmacy records, Respondent, or an employee or agent in his office, authorized prescriptions for various dangerous drugs for Cameron M. between April 5, 2000, and May 5, 2004, including five prescriptions for Amoxicillin, two prescriptions for

Ciloxan OP, three prescriptions for penicillin, and single prescriptions for Dicloxacillin, Flonase, and Kenalog OR. None of these prescriptions were documented in Respondent's medical chart for Cameron M. except for one prescription for Penicillin and one for Amoxicillin.[9] Respondent did not conduct or document a physical examination or record a medical indication for these prescriptions.

38. The following acts and omissions, taken singularly or collectively, constitute gross negligence in the care, treatment and prescribing of medications to Cameron M.:

a. Respondent failed to conduct or document a good faith examination for all the dangerous drugs and controlled substances that were prescribed for Cameron M.;

b. Respondent did not determine or document a medical indication for all the dangerous drugs and controlled substance that were prescribed for Cameron M.;

c. Respondent did not conduct or document any physical examinations, dates of patient visits, vital signs, descriptions of presenting complaints, medical history, diagnoses, treatment plan, or monitoring of Cameron M.'s condition or the effects of the medications;

d. Respondent failed to document any medical justification for the diagnoses apparently being treated by prescribing dangerous drugs and controlled substances to Cameron M.;

e. Respondent failed to consult or coordinate care with, or refer Cameron M.'s to, a physician or psychiatrist who could treat her for ADD;

f. Respondent failed to document all the prescriptions or refills that were authorized by him, or an employee or agent in his office, to be filled at the pharmacy for Cameron M. under his name. He failed to train, properly supervise, or control his staff or other people in his office who telephoned prescriptions or refills to the pharmacy to be filled for Cameron M. under his name;

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9. A second prescription for Amoxicillin was authorized by Respondent according to a note in the medical record for Jacquie M. in which Jacquie M. asks "Heather" to phone in prescriptions for "Camy" for Phenergan with Codeine and Amoxicillin.

g. By prescribing medications for chronic conditions, Respondent directly or indirectly represented himself as the treating physician for Cameron M. who was writing or authorizing these prescriptions in the course of his usual practice when, in fact, Cameron M. was not under Respondent's care and treatment for the conditions for which the drugs were prescribed;

h. Respondent was not a designated practitioner serving in the absence of Cameron M.'s treating physician(s) when he issued or authorized these prescriptions, he did not limit the amount of the drugs prescribed to the amount necessary to maintain the patient until the return of her practitioner and for no longer than 72 hours, and he did not possess or utilize Cameron M.'s medical records before ordering these prescriptions;

i. Respondent ordered laboratory tests for Cameron M. without determining or documenting a reason for the tests. He failed to document that he reviewed or followed-up on the results, or that he consulted with or referred the results to her treating physician;

j. Respondent failed to conduct or to document periodic patient visits with Cameron M. to evaluate the treatment given, and to monitor any side effects from the medications and her medical condition;

k. Respondent continued to treat and to prescribe dangerous drugs and controlled substances to his daughter for conditions that were chronic and not emergency situations, and he failed to refer her care to another physician who was objective and properly trained to handle her medical condition.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligence in the Care of Jacquie M. and Cameron M.)

39. Respondent is subject to disciplinary action under section 2234, subdivisions (a) and (c), of the Code in that he was repeatedly negligent in his care, treatment, and prescribing of drugs to Jacquie M. and Cameron M. The facts and circumstances set forth in paragraphs 18 through 38 above are incorporated here by reference, and constitute repeated negligence.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

40. Respondent is subject to disciplinary action under section 2234, subdivisions (a) and (d), of the Code in that he was incompetent in his care, treatment, and prescribing of drugs to Jacquie M. and Cameron M. The circumstances are as follows:

a. The facts and circumstances set forth in paragraphs 18 through 38 above are incorporated here by reference;

b. In addition, Respondent practices as a general, vascular and bariatric surgeon. He does not have specialized training, and did not competently manage several of the medical conditions for which he treated Jacquie M. and Cameron M. with drugs, including ADD, hypertension, hypothyroidism, and migraine headaches;

c. Respondent did not exhibit a knowledge of, or comply with the standards of care and monitoring parameters for treating ADD, hypertension, and hypothyroidism which require, among other things: periodic patient visits to evaluate the treatment given and the medications for side effects; taking and recording certain vital signs; repeating laboratory tests, reviewing, analyzing, and documenting the results for any changes in the patient's condition or effects of the medications;

d. Respondent did not exhibit a knowledge of, or comply with the requirements for prescribing pain medications and controlled substances, including the record keeping requirements, assessing the patient for medication abuse or addiction, using a stepped approach, or modifying the treatment regimen, by prescribing efficacious treatments or prophylactic medications that are not habit forming;

e. Respondent's medical charts show a lack of knowledge of what information is necessary to obtain in the patient visit and to document in the record, including history, physical exam, testing, if any, assessment, treatment plan and follow-up plan;

f. The care received by Jacquie M. and Cameron M. showed a lack of monitoring of their medical conditions, especially ADD, hypertension, and

hypothyroidism. The medical records lack any justification for the antibiotics that were prescribed;

g. The care received by Jacquie M. and Cameron M. showed a lack of monitoring of their medications and the effects of those medications;

h. Respondent did not manage Jacquie M.'s elevated cholesterol levels or low potassium levels;

i. Jacquie M.'s diagnosis of migraine headaches is not documented with any supporting data. Respondent's continued treatment with Butalbital is not supported by the documentation, and there is no documentation that current, superior available treatments were considered by Respondent;

j. The large quantity of Butalbital prescribed to Jacquie M. should have raised concerns regarding the possibility of abuse or addiction, but there is no documentation that Respondent considered this possibility.

FOURTH CAUSE FOR DISCIPLINE

(Violation of Drug Statutes)

41. Respondent is subject to disciplinary action under sections 2234, subdivision (a), 2238, 2241.5, and 2242 of the Code, in conjunction with sections 11153, 11154 and 11171 of the Health and Safety Code in that he prescribed dangerous drugs and controlled substances to Jacquie M. and Cameron M. outside the course of his usual practice of medicine, and he did not conduct or document a good faith examinations or medical indications for the medications, or keep records of all the drugs prescribed. The facts and circumstances set forth in paragraphs 18 through 40 above are incorporated here.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Medical Records)

42. Respondent is subject to disciplinary action under sections 2266 in conjunction with 2234, subdivision (a) of the Code in that he failed to maintain adequate and accurate records relating to the care, treatment and prescribing of medications to Jacquie M. and Cameron M. The facts and circumstances set forth in paragraphs 18 through 41 above are

incorporated here.

SIXTH CAUSE FOR DISCIPLINE

43. Respondent is subject to disciplinary action under sections 2234, and 2234 subdivision (a) of the Code in that he committed general unprofessional conduct by treating and prescribing medications to family members Jacquie M. and Cameron M., including prescribing controlled substances, on an ongoing basis, without referring them to, or consulting and coordinating their care with, an independent, objective physician. The facts and circumstances set forth in paragraphs 18 through 42 above are incorporated here.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

1. Revoking or suspending Physician and Surgeon's Certificate No. G 50724, issued to Stephen McColgan, M.D..

2. Revoking, suspending or denying approval of Stephen McColgan, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering Stephen McColgan, M.D. to pay the Division of Medical Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;

4. Taking such other and further action as deemed necessary and proper.

DATED: April 6, 2005

DAVID T. THORNTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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